Health Benefits Planning

Health Needs Assessment

Name(s) and Age

CURRENT Health Plan
Carrier:
Premium:
Deductible:

QUESTION ONE: How often do you go to the doctor in one year? 0-1 2-4 5+

Any chronic conditions? No / Yes:

Any pre-existing conditions? (past 24-36 months only) No / Yes:

Medicine(s)

Do you have any preferred Doctor(s) or Clinic? No / Yes:

Do you use Mental Health / Therapy services?

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